

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-000040

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 3000 Primary Registration District No. 3000 Registrar's No. 3/

FILED JAN 28 1963

VS 300  
Rev. 4/59

10017

20017

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94200

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12 90-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kirksville</u>		c. CITY OR TOWN <u>Kirksville</u>	
Length of stay in 1b <u>years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital; give location) HOSPITAL OR INSTITUTION <u>915 East Cottonwood</u>		d. STREET ADDRESS (If outside, give location) <u>915 East Cottonwood</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN B. ROLLINS</u>		4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/3/01</u>
9. AGE (last birthday) <u>62</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee, International Shoe Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bible Grove, Mo.</u>	
11. BIRTHPLACE (City and state or country) <u>U S</u>		12. CITIZEN OF WHAT COUNTRY <u>U S</u>	
13a. FATHER'S NAME <u>Joseph Rollins</u>		13b. MOTHER'S MAIDEN NAME <u>Mary UNK</u>	
14. NAME OF HUSBAND OR WIFE <u>Marie Downing Rollins</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes 12/11/20-2/28/21</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Marie Rollins, Kirksville, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease with auricular fibrillation and decompensation.</u>		2 years.	
DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Kirksville, Missouri</u>		
20g. COUNTY <u>Adair</u>		20h. STATE <u>Mo.</u>	
21. I attended the deceased from <u>November 1960</u> to <u>1-21-63</u> and last saw him alive on <u>1-18-63</u> Death occurred at <u>1:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>[Signature]</u>		22b. ADDRESS <u>Kirksville, Missouri</u>	
22c. DATE SIGNED <u>1-24-63</u>		22d. LOCATION (City, town, or county) (State) <u>Kirksville, Adair, Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan 24/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Park</u>	
23d. FUNERAL DIRECTOR <u>Foster Memorial Home, Kirksville, Mo.</u>		23e. ADDRESS <u>1-25-1963</u>	
24. DATE RECD. BY LOCAL REG. <u>1-25-1963</u>		25. REGISTRAR'S SIGNATURE <u>Norris W. Ratliff</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

FEB 1 1963

J. B. Jones, M.D.

No permit issued  
0-0-09

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Nova E. Foster*  
Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Kirksville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.